Form 5500

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Annual Return/Report of Employee Benefit Plan

This form is required to be filed for employee benefit plans under sections 104 and 4065 of the Employee Retirement Income Security Act of 1974 (ERISA) and sections 6047(e), 6057(b), and 6058(a) of the Internal Revenue Code (the Code).

➤ Complete all entries in accordance with the instructions to the Form 5500.

OMB Nos, 1210-0110 1210-0089

2015

This Form is Open to Public Inspection

Part I	Annual Report I	dentification Information			(1)	
		scal plan year beginning 01/01/2	015	and ending 12/31	./2015	
A This re	turn/report is for:	a multiemployer plan;		loyer plan (Filers checking this mployer information in accordar	box must attach a list of ice with the form instructions); or	
		🗓 a single-employer plan;	a DFE (specify	<u> </u>	8	
B This re	turn/report is:	the first return/report;	the final return.	/report;		
		an amended return/report;	a short plan ye	ear return/report (less than 12 m	onths).	
C If the p	olan is a collectively-bar	gained plan, check here			▶□	
D Check	box if filing under:	X Form 5558;	automatic exter	nsion;	the DFVC program;	
		special extension (enter description)				
Part II	Basic Plan Inf	formation—enter all requested informa	ition			
1a Name	e of plan				1b Three-digit plan	
LAN	S WELFARE BENE	FIT PLAN FOR RETIREES			number (PN) ▶ 502 1c Effective date of plan	
					06/01/2006	
2a Plan	sponsor's name (emplo	yer, if for a single-employer plan)			2b Employer Identification	
		m, apt., suite no. and street, or P.O. Box) e, country, and ZIP or foreign postal code	(if foreign, see instri	uctions)	Number (EIN) 20-3104541	
LOS ALAMOS NATIONAL SECURITY, LLC			(,	,	2c Plan Sponsor's telephone	
					number	
			505-664-0367			
POST	C OFFICE BOX 16	663, MS P280			2d Business code (see instructions)	
7.09	ALAMOS	NM 87545			541990	
ПОЗ	ALAMOD	NH 0/343				
Caution:	A penalty for the late	or incomplete filing of this return/repor	t will be assessed	unless reasonable cause is es	stablished.	
		ner penalties set forth in the instructions, l well as the electronic version of this return				
	\sim	Λ	1 .			
SIGN HERE	Koalind D.	Jones	8/16/16	ROSALIND D. TORREN	ICE	
	Signature of plan adm	ninistrator	Date	Enter name of individual signi	ng as plan administrator	
SIGN						
	Signature of employe	r/plan sponsor	Date	Enter name of individual signi	ng as employer or plan sponsor	
01011						
SIGN HERE						
	Signature of DFE		Date	Enter name of individual signi		
Preparer's	s name (including firm n	ame, if applicable) and address (include r	oom or suite numbe	r) Prepa	arer's telephone number	

o _a	a	e	2

3a	Plan administrator's name and address Same as Plan Sponsor		ninistrator's EIN 20-3104541
	BENEFITS AND INVESTMENT COMMITTEE LOS ALAMOS NATIONAL SECURITY, LLC	3c Adm	inistrator's telephone
	POST OFFICE BOX 1663, MS P280	num 5	nber 05-664-0367
	LOS ALAMOS NM 87545		
4	If the name and/or EIN of the plan sponsor has changed since the last return/report filed for this plan, enter the name, EIN and the plan number from the last return/report:	4b EIN	
а	Sponsor's name	4c PN	
5	Total number of participants at the beginning of the plan year	5	5,908
6	Number of participants as of the end of the plan year unless otherwise stated (welfare plans complete only lines 6a(1), 6a(2), 6b, 6c, and 6d).		
a(1	Total number of active participants at the beginning of the plan year	6a(1)	0
a(2	2) Total number of active participants at the end of the plan year	6a(2)	0
b	Retired or separated participants receiving benefits	6b	5,970
С	Other retired or separated participants entitled to future benefits	6c	0
d	Subtotal. Add lines 6a(2), 6b, and 6c.	6d	5,970
е	Deceased participants whose beneficiaries are receiving or are entitled to receive benefits	6e	
f	Total. Add lines 6d and 6e.	6f	
g	Number of participants with account balances as of the end of the plan year (only defined contribution plans complete this item)	6g	
h	Number of participants that terminated employment during the plan year with accrued benefits that were less than 100% vested	6h	
7	Enter the total number of employers obligated to contribute to the plan (only multiemployer plans complete this item)	7	
b	If the plan provides pension benefits, enter the applicable pension feature codes from the List of Plan Characteristics Code. If the plan provides welfare benefits, enter the applicable welfare feature codes from the List of Plan Characteristics Code. 4A 4D 4E 4G 4Q	s in the in	
9a	Plan funding arrangement (check all that apply) (1)	insurance	contracts
10	Check all applicable boxes in 10a and 10b to indicate which schedules are attached, and, where indicated, enter the number		ed. (See instructions)
2	Pension Schedules b General Schedules		
a	(1) R (Retirement Plan Information) (1) H (Financial Inform	nation)	
	(2) MB (Multiemployer Defined Benefit Plan and Certain Money Purchase Plan Actuarial Information) - signed by the plan actuary (2) I (Financial Information of the plan of th	mation) er Informa	tion)
	(3) SB (Single-Employer Defined Benefit Plan Actuarial Information) - signed by the plan actuary (6) G (Financial Trans		

P	ac	ıe	3
г	au	10	v

Part III	Form M-1 Compliance Information (to be completed by welfare benefit plans)
2520.101-	provides welfare benefits, was the plan subject to the Form M-1 filing requirements during the plan year? (See instructions and 29 CFR 2.) Yes 🔯 No checked, complete lines 11b and 11c.
11h is the plan	currently in compliance with the Form M-1 filing requirements? (See instructions and 29 CFR 2520.101-2.)
enter the F	Receipt Confirmation Code for the 2015 Form M-1 annual report. If the plan was not required to file the 2015 Form M-1 annual report, Receipt Confirmation Code for the most recent Form M-1 that was required to be filed under the Form M-1 filing requirements. (Failure valid Receipt Confirmation Code will subject the Form 5500 filing to rejection as incomplete.)
Receipt Co	onfirmation Code

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information

OMB No. 1210-0110

2015

This Form is Open to Public

		pursuant to E	ERISA section 103(a)(2)				Inspection
For calendar plan year 20°	15 or fiscal plan	year beginning 01/01/2	2015	and en	ding	12/31/20	15
A Name of plan LANS WELFARE E	BENEFIT PL	AN FOR RETIREES			e-digit number (Pl	N) •	502
C Plan sponsor's name a	s shown on line	2a of Form 5500		D Emplo	yer Identific	ation Number	(EIN)
				20 210	· 4 - 4 1		
LOS ALAMOS NAT				20-310			
		ing Insurance Contract (Individual contracts grouped as					
1 Coverage Information:		Training of the date of the da					
*							
(a) Name of insurance cal	rrier						
ARAG INSURANC	E COMPANY						
a	(c) NAIC	(d) Contract or	(e) Approximate nu			Policy or c	ontract year
(b) EIN	code	identification number	persons covered a policy or contrac		(f)	From	(g) To
42-1338303	34738	14822*	2,228		01/0	1/2015	12/31/2015
2 Insurance fee and commendescending order of the		tion. Enter the total fees and total	al commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total a	mount of comm	nissions paid		(b) To	tal amount	of fees paid	
3 Persons receiving com	missions and fe	es. (Complete as many entries	as needed to report all	persons).			
	(a) Name ar	nd address of the agent, broker,	or other person to who	m commiss	ions or fees	were paid	
	-						
(b) Amount of sales an	d base	Fee	es and other commission	ns paid			
commissions pai	d	(c) Amount	(d) Purpose			(e) Organization code	
	(a) Name ar	nd address of the agent, broker,	or other person to whor	n commissi	ions or fees	were paid	
¥							
(la) Amaza at a Caralla	dhaaa	Fee	es and other commission	ns paid			
(b) Amount of sales an commissions pai		(c) Amount		(d) Purpose			(e) Organization code
	-			** ***********************************			
For Panarwork Poduction	n Act Notice ar	od OMB Control Numbers see	the instructions for F	orm 5500			

Schedule A (Form 5500) 2015 v. 150123

Schedule A (Form 5500)	2015	Page 2 -		
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
(h) Assessment of colors and base		Fees and other commissions paid	(e) Organization	
(b) Amount of sales and base commissions paid	(c) Amount	(d) Purpose	code	
1		4		
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	ime and address of the agent, broke	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base Fees and other commissions paid				
commissions paid	(c) Amount	(d) Purpose	code	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid	<u> </u>	
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	
			1	
(a) Na	me and address of the agent, broke	r, or other person to whom commissions or fees were paid		
(b) Amount of sales and base		Fees and other commissions paid	(e) Organization	
commissions paid	(c) Amount	(d) Purpose	code	

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Pa	rt II	Where individual contracts are provided, the entire group of such indiv	ridual contrac	ets with each carrier may	be treated as a	unit for purposes of
4	Curr	this report. ent value of plan's interest under this contract in the general account at year	end		4	
		ent value of plan's interest under this contract in the general accounts at year			5	
		tracts With Allocated Funds:				
	а	State the basis of premium rates				
	_					
	b	Premiums paid to carrier			6b	
	C	Premiums due but unpaid at the end of the year			6c	
	d	If the carrier, service, or other organization incurred any specific costs in co retention of the contract or policy, enter amount	nnection witr	tne acquisition or	6d	
		Specify nature of costs				
	e	Type of contract: (1) individual policies (2) group deferre (3) other (specify)				
_	f	If contract purchased, in whole or in part, to distribute benefits from a termin		- Lond		
7	Cont a	tracts With Unallocated Funds (Do not include portions of these contracts ma Type of contract: (1) deposit administration (2) immedia				
		(3) guaranteed investment (4) other	•			
	b	Balance at the end of the previous year			7b	
	С	Additions: (1) Contributions deposited during the year				
		(2) Dividends and credits	70 70 70			
		(3) Interest credited during the year(4) Transferred from separate account	- 4.53			
		(5) Other (specify below)	7c(5)			
		•	10(0)			
		(6)Total additions		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7c(6)	C
	d	Total of balance and additions (add lines 7b and 7c(6)).		,,	7d	0
		Deductions:				
		(1) Disbursed from fund to pay benefits or purchase annuities during year				
		(2) Administration charge made by carrier	7e(2)			
		(3) Transferred to separate account				
		(4) Other (specify below)	7e(4)			
		>				
					70(5)	
	£	(5) Total deductions			7e(5)	
	t	Balance at the end of the current year (subtract line 7e(5) from line 7d)			7f	(

	Schedule A (Form 5500) 2015		Pa	ge 4	
Part II	I Welfare Benefit Contract Informa If more than one contract covers the same g information may be combined for reporting g the entire group of such individual contracts	roup of employees of the sa ourposes if such contracts ar	e experienc	ce-rated as a unit. Where cor	ntracts cover individual employees,
8 Ben	efit and contract type (check all applicable boxes)			
а	Health (other than dental or vision)	b Dental	с	Vision	d ☐ Life insurance
еĪ	Temporary disability (accident and sickness)	f Long-term disability	g	Supplemental unemployme	nt h Prescription drug
i [Stop loss (large deductible)	j HMO contract	k [PPO contract	I Indemnity contract
' L] Timo contract	., L] / / O contract	
m	Other (specify) PREPAID LEGAL				
Q Evn	erience-rated contracts:				
	Premiums: (1) Amount received	Έ	9a(1)		
a	(2) Increase (decrease) in amount due but unpa		9a(2)		
	(3) Increase (decrease) in unearned premium re		9a(3)		
	(4) Earned ((1) + (2) - (3))	1800500000000		9a	(4)
b	Benefit charges (1) Claims paid	CONTRACTOR	9b(1)		17/
b	(2) Increase (decrease) in claim reserves		9b(2)		
	(3) Incurred claims (add (1) and (2))			9b	(3)
	(4) Claims charged)_/
С	Remainder of premium: (1) Retention charges ((3)
•	(A) Commissions	_	9c(1)(A)		
	(B) Administrative service or other fees		9c(1)(B)		_
	(C) Other specific acquisition costs	THE PROPERTY OF THE PROPERTY O	9c(1)(C)		
	(D) Other expenses		9c(1)(D)		
	(E) Taxes		9c(1)(E)		
	(F) Charges for risks or other contingencies		9c(1)(F)		
	(G) Other retention charges		9c(1)(G)		
	(H) Total retention		1.33.3.	9c(1	V(H)

	(2) Dividends or retroactive rate refunds. (Thes	e amounts were paid in d	casn, or 📙	credited.) 9c	(2)

9d(1) 9d(2)

9d(3)

9e

10a

10b

265,736

d Status of policyholder reserves at end of year: (1) Amount held to provide benefits after retirement.....

e Dividends or retroactive rate refunds due. (Do not include amount entered in line 9c(2).).....

a Total premiums or subscription charges paid to carrier
 b If the carrier, service, or other organization incurred any specific costs in connection with the acquisition or

retention of the contract or policy, other than reported in Part I, line 2 above, report amount.....

Specify	naturo	of costs	•
Specify	nature	OI COSIS	

10 Nonexperience-rated contracts:

Part IV	Provision of Information			
11 Did th	e insurance company fail to provide any information necessary to complete Schedule A?	Yes	X No	

¹² If the answer to line 11 is "Yes," specify the information not provided.

Form 5500 Schedule A Information

Plan Sponsor's Name: LOS ALAMOS NATIONAL SECURITY, LLC - RETIREES

Part 1 -- Information Concerning Insurance Contract Coverage, Fees and Commissions

1. Coverage								
1.a. Name of Insurance Carrier:	ARAG Insurance Company							
1.b. EIN:	42-1338303							
1.c. NAIC Code:	34738							
1.d. Contract Number or Identification								
Number: 1.e. Approximate Number of Persons Covered	14822-0002-009, 14822-0002-010, 14822- 0002-011, 14822-0002-012, 14822-0002- 013, 14822-0002-014							
at End of Policy or Contract Year:								
1.f. From:	1/1/2015							
1.g. To:	12/31/2015							
Insurance Fees and Commission	ns Paid to Agents, Brokers, and Other Persons.							
2.a. Total Amount of Commissions Paid:	\$0.00							
2.b. Total Fees Paid / Amount:	\$0.00							
3. Persons Recei	ving Commissions and Fees							
3.a. Name and Address of the Agents, Brokers Brokers, or Other Persons To Whom Commission or Fees Were Paid:								
3.b. Amount of Commissions Paid:	\$0.00							
3.c. Fees Paid / Amount:	\$0.00							
3.d. Fees Paid / Purpose:								
3.e. Organization Code:	3							
Oth	ner Information							
Premiums Paid \$265,735.63								

** Approximate number of persons covered uses the following factors: Individual 1, Family 2, Composite 2, Two-Party 2

Certification of Accuracy

ARAG Insurance Company and/or ARAG, LLC, administrators of the Plan, hereby certify that the Schedule A to Form 5500 annual Return/Report of Employee Benefit Plan information and statements furnished pursuant to 29 U.S. Code of Federal Regulations § 2520.103-5(c) is complete and accurate.

Andrea Morse, Treasurer and CFO

4/18/2016

SCHEDULE A

(Form 5500)

Department of the Treasury Internal Revenue Service Department of Labor

Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2)

OMB No. 1210-0110

2015

This Form is Open to Public

		pursuant to	ENISA Section 103(a)(2)				Inspection
For calendar plan year 201	5 or fiscal pla	n year beginning 01/01,	/2015	and en	ding	12/31/20	15
A Name of plan LANS WELFARE B	ENEFIT P	LAN FOR RETIREES		1	e-digit number (Pl	N) •	502
C Plan sponsor's name a	s shown on lin	e 2a of Form 5500		D Emplo	yer Identific	ation Number	(EIN)
				20 210			
LOS ALAMOS NAT				20-310			
		ning Insurance Contract Individual contracts grouped a					
1 Coverage Information:							
(a) Name of insurance car							
VISION SERVIC	E PLAN						
(b) EIN	(c) NAIC	(d) Contract or	(e) Approximate nu persons covered a			Policy or c	ontract year
(b) EIN	code	identification number	policy or contrac		(f)	From	(g) To
36-3560825	32395	12284390*	2,835		01/0	1/2015	12/31/2015
2 Insurance fee and commodescending order of the		ation. Enter the total fees and to	otal commissions paid. L	ist in line 3	the agents,	brokers, and o	ther persons in
(a) Total amount of commissions paid (b) Total amount of fees paid							
1524							
3 Persons receiving com	missions and f	ees. (Complete as many entrie	s as needed to report all	persons).			
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
(b) Amount of sales an	d base	F	ees and other commission	ns paid			
commissions pai		(c) Amount	(d) Purpose			(e) Organization code	
		l					
	(a) Name a	and address of the agent, broke	r, or other person to who	m commiss	ions or fees	were paid	
							1
(b) Amount of sales an			ees and other commission				(a) Organization and
commissions paid	a	(c) Amount		(d) Purpose	-		(e) Organization code

For Paperwork Reduction Act Notice and OMB Control Numbers, see the instructions for Form 5500.

Schedule A (Form 5500) 2015 v. 150123

(e) Amount of sales and base commissions paid (b) Amount of sales and base rommissions paid (c) Amount (d) Purpose (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) O (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) O (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) O (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) O (b) Amount of sales and base commissions paid (c) Amount (d) Purpose	chedule A (Form 5500) 201	,	Page 2 -	-
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(b) Amount of sales and base commissions paid (c) Amount (d) Purpose (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) O (e) O (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	missions paid	(c) Amount	(d) Purpose	code
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(b) Amount of sales and base commissions paid (c) Amount (d) Purpose (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) O (e) O (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	(a) Name a	nd address of the agent broke	er or other person to whom commissions or fee	s were naid
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				(e) Organization
(b) Amount of sales and base commissions paid (c) Amount (d) Purpose (e) O (a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	(a) Name a	nd address of the agent, broke	r, or other person to whom commissions or fee	s were paid
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid				
(a) Name and address of the agent, broker, or other person to whom commissions or fees were paid	nt of sales and base		Fees and other commissions paid	(e) Organizatio
		(c) Amount	(d) Purpose	code
Fees and other commissions naid	(a) Name a	nd address of the agent, broke	er, or other person to whom commissions or fee	s were paid
Fees and other commissions naid				
(b) 7 illiount of sales and base			Fees and other commissions paid	(e) Organizatio
commissions paid (c) Amount (d) Purpose	missions paid	(c) Amount	(d) Purpose	code

О	~~	_	2
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			*!)	
Part I	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such indivithis report.	idual contracts with each carrier may	be treated as a unit	for purposes of
1 Cur	rent value of plan's interest under this contract in the general account at year	end	4	
5 Cur	rent value of plan's interest under this contract in separate accounts at year e	nd	5	
Con	tracts With Allocated Funds:			
а	State the basis of premium rates			
b	Premiums paid to carrier		6b	
C	Premiums due but unpaid at the end of the year	0	6c	
d	If the carrier, service, or other organization incurred any specific costs in corretention of the contract or policy, enter amount		6d	
	Specify nature of costs			
е	Type of contract: (1) individual policies (2) group deferre	d annuity		
	(3) other (specify)			
	_			
f	If contract purchased, in whole or in part, to distribute benefits from a termin			
7 Con	tracts With Unallocated Funds (Do not include portions of these contracts ma	•		
а	Type of contract: (1) deposit administration (2) immedia	ate participation guarantee		
	(3) guaranteed investment (4) other			
	_			
b	Balance at the end of the previous year		7b	
С	Additions: (1) Contributions deposited during the year	. 7c(1)		
	(2) Dividends and credits			
	(3) Interest credited during the year			
	(4) Transferred from separate account	7c(4)		
	(5) Other (specify below)	7c(5)		
	•			
			1	
	(0.7)		7-(6)	
۸	(6)Total additions	~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~	7c(6) 7d	0
	Total of balance and additions (add lines 7b and 7c(6)).		/u	0
е	Deductions: (1) Dishursed from fund to pay benefits or purchase annuities during year.	7e(1)		
	Disbursed from fund to pay benefits or purchase annuities during year Administration charge made by carrier	- 121		
	(3) Transferred to separate account			
	(4) Other (specify below)	7e(4)		
		-3.2		
	•			
			1	
	(5) Total deductions		7e(5)	0
f	Balance at the end of the current year (subtract line 7e(5) from line 7d)		7f	0

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12 If the answer to line 11 is "Yes," specify the information not provided.

P	art II	If more than one contract covers the same g		ama ampla	var(a) or mambara	of the came am	volovoo organizations(s)	tho
		information may be combined for reporting p the entire group of such individual contracts	urposes if such contracts a	are experier	nce-rated as a unit.	Where contract	ts cover individual emplo	oyees,
8	Bene	efit and contract type (check all applicable boxes)						
	а	Health (other than dental or vision)	b Dental	С	X Vision		d Life insurance	
	еГ	Temporary disability (accident and sickness)	f Long-term disabilit	у д	Supplemental ur	nemployment	h Prescription drug	
	i	Stop loss (large deductible)	j HMO contract	k	=		I Indemnity contract	
	m	Other (specify)			_			
9	Expe	rience-rated contracts:						
		Premiums: (1) Amount received		9a(1)				
		(2) Increase (decrease) in amount due but unpai	db					
		(3) Increase (decrease) in unearned premium res	serve	9a(3)				
		(4) Earned ((1) + (2) - (3))				9a(4)		
	b	Benefit charges (1) Claims paid						
		(2) Increase (decrease) in claim reserves		9b(2)				
		(3) Incurred claims (add (1) and (2))				1.0028.3.061		
		(4) Claims charged				9b(4)		
	C	Remainder of premium: (1) Retention charges (c	n an accrual basis)					
		(A) Commissions		9c(1)(A)				
		(B) Administrative service or other fees		9c(1)(B)				
		(C) Other specific acquisition costs		9c(1)(C)				
		(D) Other expenses		9c(1)(D)			_	
		(E) Taxes		9c(1)(E)			_	
		(F) Charges for risks or other contingencies,		9c(1)(F)			_	
		(G) Other retention charges		9c(1)(G)				
		(H) Total retention						
		(2) Dividends or retroactive rate refunds. (These	amounts were 📗 paid in	cash, or	credited.)	9c(2)		
	d	Status of policyholder reserves at end of year: (1) Amount held to provide I	penefits afte	er retirement,	9d(1)		
		(2) Claim reserves				9d(2)		
		(3) Other reserves				9d(3)		
	е	Dividends or retroactive rate refunds due. (Do n	ot include amount entered	in line 9c(2	2).)	9e		
10) Nor	nexperience-rated contracts:				19		
	а	Total premiums or subscription charges paid to o	arrier			10a	55	8,677
		If the carrier, service, or other organization incur						
		retention of the contract or policy, other than rep ecify nature of costs	orted in Part I, line 2 above	e, report arr	iount			
	Οp.	only hatare or cooks /						
			¥5			2		
		2						
_	4 45	(Developer of left at						
Pa	art IV	Provision of Information					n	
11	אום ו	the insurance company fail to provide any inform	ation necessary to comple	ate Schedul	ΑΔ?	☐ Yes	X No	

SCHEDULE A (FORM 5500) Insurance Information

If Schedule A information is required to file a complete Form 5500 C/R, information from this form must be transcribed onto IRS Schedule A (Form 5500) Insurance Information form (Cat. No. 13505I) as required by federal regulation. IF YOU HAVE ANY QUESTIONS REGARDING THE TRANSPOSITION OF INFORMATION CONTAINED IN THIS REPORT, CONTACT YOUR INTERNAL COMPLIANCE OFFICER.

LANS-RETIREES
FELIZ VIGIL
TA-3 OTOWI BUILDING 261
2ND FLOOR, MS P280
LOS ALAMOS NM 87544

Group No. 12284390-0005
Ins. Carrier: Vision Service Plan
Ins. Carrier NAIC Code No: 32395
Ins. Carrier FEIN: 363560825

Benefit Type: Vision Care

Policy or Contract Year: 01/01/2015 - 12/31/2015

Group Legal Name and Address: LOS ALAMOS NATIONAL SECURITY, LLC. TA-3 OTOWI BUILDING 261 LOS ALAMOS NM 87544

Approximate Number of Persons Covered at the End of Policy or Contract Year: 2829

Premium or Administrative Fee Rate:

\$10.53/\$21.07/\$21.28/\$26.34

Fees, Payments, Claims

Total Administrative Fees Paid to Carrier: Total Payments Made to Carrier: Total Claims Paid by Carrier:

Paid for Policy or Contract Year

> \$89,282.94 \$558,018.44 \$312,878.68

Due and Unpaid at End of Policy or Contract Year

> \$0.00 \$0.00

Vision Service Plan hereby certifies that this statement furnished pursuant to 29 CFR 2520.103 - 5 (c) is complete and accurate as of: April 20, 2016

SCHEDULE A (FORM 5500) Insurance Information

If Schedule A information is required to file a complete Form 5500 C/R, information from this form must be transcribed onto IRS Schedule A (Form 5500) Insurance Information form (Cat. No. 13505I) as required by federal regulation. IF YOU HAVE ANY QUESTIONS REGARDING THE TRANSPOSITION OF INFORMATION CONTAINED IN THIS REPORT, CONTACT YOUR INTERNAL COMPLIANCE OFFICER.

LANS-RETIREES COBRA FELIZ VIGIL TA-3 OTOWI BUILDING 261 2ND FLOOR, MS P280

LOS ALAMOS NM 87544

Group No. 12284390-0006 Ins. Carrier: Vision Service Plan

Ins. Carrier NAIC Code No: 32395 Ins. Carrier FEIN: 363560825

Benefit Type: Vision Care

Policy or Contract Year: 01/01/2015 - 12/31/2015

Group Legal Name and Address: LOS ALAMOS NATIONAL SECURITY, LLC. TA-3 OTOWI BUILDING 261 LOS ALAMOS NM 87544

Approximate Number of Persons Covered at the End of Policy or Contract Year: 6

Premium or Administrative Fee Rate:

\$10.53/\$21.07/\$21.28/\$26.34

Paid for Policy or Contract Year	Due and Unpaid at End of Policy or Contract Year
\$105.30	\$0.00
\$658.12	\$0.00
<mark>\$632.87</mark>	
	Contract Year \$105.30 \$658.12

Vision Service Plan hereby certifies that this statement furnished pursuant to 29 CFR 2520.103 – 5 (c) is complete and accurate as of: April 20, 2016

SCHEDULE A (Form 5500)

Department of the Treasury Internal Revenue Service

Department of Labor Employee Benefits Security Administration

Pension Benefit Guaranty Corporation

Insurance Information

This schedule is required to be filed under section 104 of the Employee Retirement Income Security Act of 1974 (ERISA).

File as an attachment to Form 5500.

▶ Insurance companies are required to provide the information pursuant to ERISA section 103(a)(2).

OMB No. 1210-0110

2015

This Form is Open to Public Inspection

		parodantito	=1 (10) (00 0 (10) (10 0 (1) (1) (1)		mspection		
For calendar plan year 201	5 or fiscal pla	an year beginning 01/01/	2015 ar	nd ending 12/31/20	15		
A Name of plan LANS WELFARE B	ENEFIT I	PLAN FOR RETIREES		Three-digit plan number (PN)	502		
C Plan sponsor's name as	s shown on li	ne 2a of Form 5500		mployer Identification Number	(EIN)		
LOS ALAMOS NAT	IONAL SE	ECURITY, LLC	20-	3104541			
Part I Information on a separate	on Concer Schedule A	ning Insurance Contract Individual contracts grouped as	Coverage, Fees, and C a unit in Parts II and III can be	ommissions Provide information of the control on a single Schedule	mation for each contract e A.		
1 Coverage Information:							
(a) Name of insurance car HARTFORD LIFE		IDENT					
	(c) NAIC	(d) Contract or	(e) Approximate number		contract year		
(b) EIN	code	identification number	persons covered at end of policy or contract year	of (f) From	(g) To		
06-0838648	70815	ADDS07167	5,970	01/01/2015	12/31/2015		
2 Insurance fee and commodescending order of the		nation, Enter the total fees and to	tal commissions paid. List in li	ne 3 the agents, brokers, and o	other persons in		
(a) Total amount of commissions paid (b) Total amount of fees paid							
3 Persons receiving comm		fees. (Complete as many entries					
	(a) Name	and address of the agent, broker	, or other person to whom com	missions or fees were paid			
(b) Amount of sales an	d base	Fe	es and other commissions paid	1			
commissions paid		(c) Amount	(d) Pu	rpose	(e) Organization code		
	(a) Name	and address of the agent, broker	, or other person to whom com	missions or fees were paid			
	1-1			·			
(b) Amount of sales an	d base	Fe	es and other commissions paid				
commissions pair		(c) Amount	(d) Pu	rpose	(e) Organization code		

Schedule A (Form 5500) 20						
(a) Name	e and address of the agent, t	oroker, or other person to whom commissions or fees were pai	d			
-						
(b) Amount of sales and base Fees and other commissions paid						
commissions paid	(c) Amount	(d) Purpose	code			
(a) Name	e and address of the agent, b	proker, or other person to whom commissions or fees were pai	d			
(b) Amount of sales and base		Fees and other commissions paid	(e) Organiza			
commissions paid	(c) Amount	(d) Purpose	code			
(a) Name	and address of the agent h	proker, or other person to whom commissions or fees were pai	٠			
	o und address of the agent, t		u ,			
(b) Amount of sales and base		Fees and other commissions paid				
	(c) Amount		(e) Organiz			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid	(e) Organiz code			
(b) Amount of sales and base commissions paid	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organiz code			
(b) Amount of sales and base commissions paid (a) Name	(c) Amount	Fees and other commissions paid (d) Purpose	(e) Organiza code			
(b) Amount of sales and base commissions paid (a) Name	(c) Amount	Fees and other commissions paid (d) Purpose proker, or other person to whom commissions or fees were paid	(e) Organiz code			
(b) Amount of sales and base commissions paid (a) Name	(c) Amount e and address of the agent, b	Fees and other commissions paid (d) Purpose proker, or other person to whom commissions or fees were paid Fees and other commissions paid	(e) Organiz code			
(b) Amount of sales and base commissions paid (a) Name (b) Amount of sales and base commissions paid	(c) Amount e and address of the agent, t	Fees and other commissions paid (d) Purpose proker, or other person to whom commissions or fees were paid Fees and other commissions paid	d (e) Organiz			
(b) Amount of sales and base commissions paid (a) Name (b) Amount of sales and base commissions paid	(c) Amount e and address of the agent, t	Fees and other commissions paid (d) Purpose proker, or other person to whom commissions or fees were paid Fees and other commissions paid (d) Purpose	d (e) Organization (e)			
(b) Amount of sales and base commissions paid (a) Name (b) Amount of sales and base commissions paid	(c) Amount e and address of the agent, t	Fees and other commissions paid (d) Purpose proker, or other person to whom commissions or fees were paid Fees and other commissions paid (d) Purpose	d (e) Organiza			

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Pa	rt II	Investment and Annuity Contract Information Where individual contracts are provided, the entire group of such individual this report.	vidual contract	s with each carrier may b	pe treated as a	unit for purposes of
4 (Curren	t value of plan's interest under this contract in the general account at year	end		4	
		t value of plan's interest under this contract in separate accounts at year e			5	
		cts With Allocated Funds:				
	a s	tate the basis of premium rates				
	b P	remiums paid to carrier			6b	
		remiums due but unpaid at the end of the year			6c	
1	d If	the carrier, service, or other organization incurred any specific costs in coetention of the contract or policy, enter amount	nnection with	the acquisition or	6d	
	S	pecify nature of costs				
		ype of contract: (1) ☐ individual policies (2) ☐ group deferred 3) ☐ other (specify) ▶	ed annuity			
	f If	contract purchased, in whole or in part, to distribute benefits from a termination	nating plan, ch	neck here		
7 (Contra	cts With Unallocated Funds (Do not include portions of these contracts ma	aintained in se	parate accounts)		
	а т	ype of contract: (1) deposit administration (2) immedia	ate participatio	on guarantee		
		(3) guaranteed investment (4) other	•			
		(5) U guaranteed investment (4) U outst			φ.	
	b B	salance at the end of the previous year			7b	
_		dditions: (1) Contributions deposited during the year	1 - (4)			
		2) Dividends and credits	- 100			
	,	3) Interest credited during the year	= (0)			
		4) Transferred from separate account	- (4)			
	(5	5) Other (specify below)	7c(5)			
	Ì					
	(6	5)Total additions			7c(6)	(
	d To	otal of balance and additions (add lines 7b and 7c(6)).			7d	C
		eductions:				
	(1) Disbursed from fund to pay benefits or purchase annuities during year	7e(1)			
) Administration charge made by carrier	7e(2)			
	•) Transferred to separate account	= (0)			
) Other (specify below)				
	•					
	ŕ					
				-	70(5)	
	,) Total deductions		······	7e(5)	(
		alance of the end of the ourrent upor (cultivate line 7a(E) from line 7d)		the state of the s		

Pag	e	4

Pa	art II	I Welfare Benefit Contract Informat If more than one contract covers the same gi information may be combined for reporting pi the entire group of such individual contracts of	roup of employees of the urposes if such contracts	are experience	ce-rated as a unit. W	here contracts	
8	Bene	efit and contract type (check all applicable boxes)					
	а「	Health (other than dental or vision)	b Dental	c	Vision		d Life insurance
	еГ	Temporary disability (accident and sickness)	f Long-term disabil	ity g 🗍	Supplemental uner	nployment	h Prescription drug
	i	Stop loss (large deductible)	i HMO contract	~ =	PPO contract		I Indemnity contract
	m [2	Other (specify) ACCIDENTAL DEATH	- L		_		
9	Expe	rience-rated contracts:					
	•	Premiums: (1) Amount received		9a(1)			
		(2) Increase (decrease) in amount due but unpaid					
		(3) Increase (decrease) in unearned premium res					
		(4) Earned ((1) + (2) - (3))				9a(4)	
		Benefit charges (1) Claims paid					
		(2) Increase (decrease) in claim reserves			14	_	
		(3) Incurred claims (add (1) and (2))				9b(3)	
		(4) Claims charged				9b(4)	
		Remainder of premium: (1) Retention charges (c					
	•	(A) Commissions		9c(1)(A)			
		(B) Administrative service or other fees					
		(C) Other specific acquisition costs					
		(D) Other expenses					
		(E) Taxes					
		(F) Charges for risks or other contingencies.					
		(G) Other retention charges		9c(1)(G)			
		(H) Total retention				9c(1)(H)	
		(2) Dividends or retroactive rate refunds. (These					
	d		-				
	u	Status of policyholder reserves at end of year: (1					1
		(2) Claim reserves				9d(2)	
	_	(3) Other reserves				9d(3)	†
40		Dividends or retroactive rate refunds due. (Do n	ot include amount entere	a in line 9c(2)	.)	9e	
10		nexperience-rated contracts:				40-	66,368
	_	Total premiums or subscription charges paid to c				10a	66,366
		If the carrier, service, or other organization incurs retention of the contract or policy, other than repectify nature of costs				10b	
D	art I\	∕ Provision of Information					
				1-1-0-1-1:	40	l voc F	X No
_11	Did	the insurance company fail to provide any inform	lation necessary to comp	lete Schedule	A?	Yes 2	X No



March 10, 2016

LOS ALAMOS NATIONAL SECURITY TAX UNIT SM 30 BIKINI ATOLL RD, MS P280 LOS ALAMOS, NM-87545

Dear Policyholder:

Attached is your certified Annual Statement of Premiums and Producer Compensation. This statement provides a concise summary of information related to your group benefits policy(ies) with The Hartford. If you are required to complete and file Schedule A to IRS Form 5500, the information contained on the statement may assist you during this process. The Hartford certifies to the accuracy and completeness of the information provided.

To help you accurately read your statement, defined below are selected terms used in the report:

- Premiums premium payments paid and applied during the policy year.
- Commissions base commissions paid to your insurance producer on premiums received and applied during the policy year.
- Fees fees are other compensation paid to your insurance producer for providing administrative or other services related to your policy. If you are filing Schedule A to IRS Form 5500, Fees should be recorded as "Fees" on Schedule A.
- Bonus Paid an allocation related to your policy or policies of contingent compensation payable to producers on all policies that were considered in determining producer's eligibility for bonus payments and/or the actual calculation of any such bonus payment. If you are filing Schedule A to IRS Form 5500, Bonus Paid should be recorded as "Fees" on Schedule A.
- Additional Compensation an allocation related to your policy or policies of non-contingent compensation (cash or non-cash) payable to producers on all policies that were considered in determining the producer's eligibility for additional compensation and/or the actual calculation of any such additional compensation. If you are filing Schedule A to IRS Form 5500, Additional Compensation should be recorded as "Fees" on Schedule A.

We appreciate your business and look forward to continuing to serve your group benefits needs. If you need additional information, please contact your Hartford representative or call Customer Service at (800) 523-2233 or via e-mail gbdcommission@hartfordlife.com.

Sincerely,

David R. Kryzanski Vice President Service Operations P.O. Box 2999

David Kujjanski

Hartford, CT 06104-2999

¹ The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

The Hartford Group Benefits Division Annual Statement of Premiums and Producer Compensation For: LOS ALAMOS NATIONAL SECURITY Page 2 of 3



Policyholder and Address LOS ALAMOS NATIONAL SECURITY TAX UNIT SM 30 BIKINI ATOLL RD, MS P280 LOS ALAMOS, NM-87545

Plan/Policy Year – 01/01/2015 to 12/31/2015

Name of Insurance Carrier	EIN	NAIC Code	Policy Number
HARTFORD LIFE AND ACCIDENT	06-0838648	70815	ADDS07167

Premium was applied as follows during the Plan/Policy Year -

Policy Number	Type of Benefit	Premium Applied	Approximate # of Lives Covered
ADDS07167	Accidental Death & Dismemberme	\$66,368.00	See Policyholder's records
	Total	\$66,368.00	

¹ The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

The Hartford Group Benefits Division Annual Statement of Premiums and Producer Compensation For: LOS ALAMOS NATIONAL SECURITY Page 3 of 3



Insurer paid the following compensation during the Plan/Policy Year -

Producer and Address	Org Code	Policy Number	Commissions Paid	Fees Paid	(1)Bonus Paid	(2)Additional Compensation Paid
HOME OFFICE DIRECT 200 HOPMEADOW ST WEATOGUE, CT-06089	3	ADDS07167	\$0.00	\$0.00	\$0.00	\$0.00
		Total	\$0.00	\$0.00	\$0.00	\$0.00

The Hartford compensates producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation, including contingent commission and other non-cash awards. Incentive compensation is based upon a variety of factors that may include the level of premium written, retention and growth of premium, overall profitability, or other performance measures. Some of our producers elect not to accept some or all forms of compensation from The Hartford. Please direct specific questions about your insurance producer's compensation to your producer.

⁽¹⁾Bonus Paid represents an allocation of contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such bonus payment. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

⁽²⁾Additional Compensation represents an allocation of non-contingent compensation (cash or non-cash) payable to the named producer on all policies that were considered in determining the producer's eligibility for and/or the actual calculation of any such additional compensation. These amounts are not directly charged to your policy premium rates but represent overhead expense incurred by The Hartford.

Form **5558** (Rev. August 2012)

Department of the Treasury Internal Revenue Service

Signature ▶

Application for Extension of Time To File Certain Employee Plan Returns

► For Privacy Act and Paperwork Reduction Act Notice, see instructions.

Information about Form 5558 and its instructions is at www.irs.gov/form5558

OMB No. 1545-0212

File With IRS Only

Pa	rt I Identification							
A	Name of filer, plan administrator, or plan sponsor (see instructions) B Filer's identifying number (see instructions)							
	LOS ALAMOS NATIONAL SECURITY, LLC Employer identification number (EIN) (9 digits XX-2							
	Number, street, and room or suite no. (If a P.O. box, see instructions)		20-3104541					
	POST OFFICE BOX 1663, MS P280		Social security number (SSN) (9 digits XXX-XX-XXXX)					
	City or town, state, and ZIP code	1						
С	LOS ALAMOS, NM 87545	-	Diam	Dlor	year endin			
C	Plan name	r	Plan number	MM	YYYY			
			1 1		DD			
	LANS WELFARE BENEFIT PLAN FOR RETIREES	5	0 2	12	31	2015		
		OFF C	CA					
Par	Extension of Time To File Form 5500 Series, and/or Form 8	900-0	3A					
1	Check this box if you are requesting an extension of time on line 2 to file the in Part 1, C above.	ne first F	Form 5500 s	series return/r	eport for the	plan listed		
2	I request an extension of time until 10 / 17 / 2016 to file Form	n 5500 s	series (see i	nstructions).		5		
_	Note. A signature IS NOT required if you are requesting an extension to file Fo			noti dotionoji				
	, , , , , , , , , , , , , , , , , , , ,							
3	I request an extension of time until/to file Form	า 8955-	SSA (see in	structions).				
	Note. A signature IS NOT required if you are requesting an extension to file Fo	orm 895	5-SSA.					
Par	The application is automatically approved to the date shown on line 2 and/the normal due date of Form 5500 series, and/or Form 8955-SSA for which and/or line 3 (above) is not later than the 15th day of the third month after the Extension of Time To File Form 5330 (see instructions)	this ex	xtension is					
4 a b c 5		ne norm	a	•	b c			
Linder	penalties of perjury, I declare that to the best of my knowledge and belief, the statements made of	on this for	m are true.	prent and comp	lete and that I	am authorized		

Date ▶